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Authority

Title 32.1, Chapter 12, *Code of Virginia*

Program Description

The State/Local Hospitalization Program (SLH) is a cooperative effort between the state and local governments that is designed to provide coverage for inpatient and outpatient hospital care, care in approved ambulatory surgical centers, and care provided in local health departments. The SLH Program was established in 1946 with participation by localities on a voluntary basis. Under the original SLH Program, local expenditures were matched by state funds at a rate of 50%. This program was repealed and a mandatory statewide program was enacted in 1989. The new program requires all localities within the Commonwealth to participate and mandates a local match, not to exceed 25% of the program benefit expenditures. This enabling legislation also transferred administration of the program from localities and the Department of Social Services to the Department of Medical Assistance Services.

Coverage for health care services is available to indigent people who are not Medicaid recipients. A person may be eligible for the SLH Program whether employed or unemployed, insured or uninsured, if the person meets the income and resource criteria established for the program. Determination of eligibility for SLH must be made by the Department of Social Services in the city or county where the applicant lives. An applicant may be eligible if his or her income is equal to or less than 100% of the federal poverty level established for the year in which the applicant is applying. Localities that had SLH income eligibility levels above 100% of poverty prior to June 30, 1989, may have a higher level under the current program. SLH is not an entitlement program; once a locality's funds are exhausted, no further benefits are offered until the next year's allocation is received.

The SLH Program is financed entirely by state and local funds with the state providing at least 75% percent of the cost by allocating the amount of funds appropriated to each locality on the basis of current estimated demand for covered services. Funds allocated to a locality can be used to pay for services provided to residents of that locality only. The Department of Medical Assistance Services calculates the state and local share allocations, administers financing, claims processing, provider reimbursement, and is responsible for provider communications. Effective July 1, 2003, the inpatient DRG reimbursement methodology was implemented to be consistent with Medicaid billing and reimbursement.